DMHMRS 02-03
attachment II

DEPARTMENT FOR MENTAL HEALTH AND MENTAL RETARDATION
REQUEST FOR AN ACCOUNTING OF DISCLOSURES

DATE_____

NAME_____

BIRTHDATE_____MEDICAL RECORD #_____

ADDRESS_____

ADDRESS TO SEND DISCLOSURE ACCOUNTING (if different from above)_____
_____

DATES REQUESTED:
(Please note: the maximum time frame that can be requested is six (6) years prior to the date of the request, but not prior to April 14, 2003)

FROM:_____ TO:_____

I understand that there may be a fee for this accounting. I also understand that the accounting will be provided within sixty (60) days, unless I am notified in writing for an extension of up to thirty (30) days.

Signature_____ Date_____

For DMHMRS Use Only
Date Received_____ Date Sent_____
Extension Requested
□ Yes □ No
Reason for extension_____
Copy of *Verification of Identity* of individual and/or legal representative
□ Yes □ No
Fees:
□ First Request in a twelve (12) month period. No Charge.
□ Subsequent request (.10 cents per page)
Total fee for this request_____

Reviewers Signature_____Date_____